

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$1,969.00 for date of service 07/25/01.
- b. The request was received on 07/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA 1450-UB-92
 - c. EOB
 - d. Medical Records
 - e. EOBs from other insurance carriers
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and a Response to a Request for Dispute Resolution
 - b. HCFA 1450-UB-92
 - c. EOB
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/13/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 08/14/02. The response from the insurance carrier was received in the Division on 08/28/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/05/02

“We are appealing the amount disallowed on the above mention[sic] claim. These charges are for **FACILITY FEES**, not professional fees. We feel that 75% paid on a hemilaminotomy & discectomy is not fair and reasonable. We feel that (Carrier) should reimburse us more appropriately as \$5907.00 does not cover our costs to perform this surgery.”

2. Respondent: Letter dated 08/28/02

“The provider has not submitted documentation that the reimbursement received does not cover its costs and allow for a reasonable profit. The documentation submitted by provider is irrelevant, as it represents payment by payors outside the workers’ compensation context; therefore, it only establishes that the provider has billed its usual and customary charge, which is not in dispute. The statute only requires that workers’ compensation insurers do not pay more than other payors. There is no requirement that they pay at the same rate.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/25/01.
2. Per the Requestor’s Table of Disputed Services, the Requestor billed the Carrier \$7,876.00 for services rendered on the above dates in dispute.
3. Per the Requestor’s Table of Disputed Services, the Carrier paid the Requestor \$5,907.00 for services rendered on the above dates in dispute.
4. The amount left in dispute is \$1,969.00.
5. The Carrier’s EOBs deny additional reimbursement as “TX M No Mar.”

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, “shall be reimbursed at a fair and reasonable rate...” The MFG reimbursement requirements for DOP states, “An MAR is listed for each code excluding documentation of procedure (DOP) codes... HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate.”

Medical documentation submitted indicates these charges are for spinal surgery. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence in regards to fair and reasonable. The provider has submitted additional reimbursement data: three example EOBs for charges billed for similar services. The carrier, according to their denial on the EOB, asserts that they have paid a fair and reasonable reimbursement, but have not submitted a methodology to support their reimbursement. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor has provided some documentation to support their position that the amount billed is fair and reasonable. The provider's position statement states, "First, it backs up our claim that other insurance carriers are in fact paying 85%-100% of our billed charges." The provider has also indicated through the submitted EOBs, that they are willing to accept 85% reimbursement as a fair and reasonable rate. Therefore, based on this information, reimbursement for the charges will be determined at 85% of the total charges. Additional reimbursement of **\$787.50**. ($\$7,876.00 \times 85\% = \$6,694.50$ minus $\$5,907.00$ already paid equals a total of $\$787.50$ additional reimbursement).

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$787.50 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 12th day of March 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division
MB/mb